Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

I. DISPUTE

1. a. Whether there should be additional reimbursement of $33,651.22 for dates of service 07/19/01 through 08/01/01?

   b. The request was received on 02/13/02.

II. EXHIBITS

1. Requestor, Exhibit I:

   a. TWCC 60
   b. HCFA(s)1450
   c. EOB/TWCC 62 forms/Medical Audit summary
   d. Medical Records
   e. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

2. Respondent, Exhibit II:

   a. TWCC 60 and Response to a Request for Dispute Resolution dated 05/08/02
   b. HCFA(s)1450
   c. Medical Audit summary/EOB/TWCC 62 form
   d. Medical Records
   e. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

3. Per Rule 133.307 (g) (3), the Division forwarded a copy of the requestor's 14 day response to the insurance carrier on 04/25/02. Per Rule 133.307 (g) (4) or (5), the carrier representative signed for the copy on 04/25/02. The response from the insurance carrier was received in the Division on 05/08/02. Based on 133.307 (i) the insurance carrier's response is timely.

4. Notice of Medical Dispute is reflected as Exhibit III of the Commission's case file.

III. PARTIES' POSITIONS

1. Requestor: The requestor did not submit a letter requesting dispute resolution.

2. Respondent:

A. "It is the carrier's position the Commission has no jurisdiction to proceed with medical dispute resolution.

This carrier respectfully requests the Commission dismiss this request for dispute resolution for all dates of service in dispute. The requestor did not properly request reconsideration of dates of service in dispute BEFORE requesting resolution as required per TWCC Rule 133.304(m). The requestor did not mark the bills for reconsideration. (Exhibit 1) Therefore, the Commission has no jurisdiction to proceed with review.

B. This carrier initially reviewed the implant charges for the implants; screws, rod, cages, and breakoff set screw; without copies of the invoices. The initial review determined the 07/19/01 through 08/01/01 hospital stay did not qualify for stop-loss reimbursement.

Upon review with copies of the invoices (Exhibit 2), it is the carrier's position the hospital bill does not qualify for stop-loss reimbursement, however, the audited bill does NOT support 75% of the amount billed ($83,302.90). It is the carrier's position the requester was due 75% of the audited charges $39,727.97 ($29,302.90 was paid upon initial review.). A total of $23,667.22 will follow under separate cover.

It is the carrier's position $27,013.80 is the proper billable amount for implants. The following demonstrates why $30,968.20 of the $57982.00 billed by the requester should not have been billed.

1. Deduct $8,153.00 from requester's charge- It is the carrier's position that no reimbursement is due for the bone stimulator as it was not preauthorized as required per TWCC Rule 134.600 (h)(3) or indicated on the TWCC 63 for prospective review. (Exhibit 3)

2. Deduct $17,223.20 from requester's charge- Review of the invoices from (Supplier) reveals the requester inflated the implantable charges for screws, rod, cages, and breakoff set screws by 81 percent. The invoices for the implants support the actual costs were $24,258 (not including shipping). The requester billed this carrier $43,907. It is the carrier's position the amount of reimbursement due was cost plus 10% or $26,683.80.

3. Deduct $789 from the requester's charge- It appears the requester billed $1119.00 for four 30cc bags of cancellous bone chips. However, the operative report does not document how much cancellous bone chips were used. Therefore, in the absence of documentation to support for four bags of cancellous bone chips, this carrier allowed the cost of one bag plus 10% or $330.

4. Deduct $4803.00 form the requester's charge- Review of the operative report does not substantiate or document that the tricortical bone blocks were used in the surgery, therefore, no reimbursement is due for this service. (Exhibit 4)

This carrier's position is supported by the Texas State Office of Administrative Hearings more than once. Exhibit 4

This carrier contacted …, the requester's contact identified on the TWCC 60, in an effort to resolve this dispute. (Requester's contact)maintained that once the total amount billed did not drop below $40,000.00 that the requester was due 75% of the inflated implantable charges as billed (i.e. 75% of the $43,907 billed under revenue code 278). It is her understanding through contacts with TWCC that the carrier does not have the right to audit the implantable charges and adjust for the hospital's inflated prices.

This carrier maintains the right to audit hospital charges as provided for by TWCC Rule 133.301, 134.401, 134.600, 133.206. Section 413.011 (b) of the Texas Labor Code mandates that the 'Guideline for medical services fees must be fair and reasonable and designed to ensure the quality of medical care and to achieve medical cost control…' It is this carrier's position that 75% of an UNLIMITED billable amount is not effective medical cost control."

IV. FINDINGS

1. Based on Commission Rule 133.307(d) (1) (2), the only dates of service eligible for review are those commencing on 07/19/01 and extending through 08/01/01.

V. RATIONALE

Medical Review Division's rationale:

The medical reports indicate that the services were performed. The medical documentation submitted by the Requestor indicates that the total hospital bill was $83,938.82. Per Rule 134.401 (c)(6) (A)(i)(iii), once the bill has reached the minimum Stop-Loss threshold of $40,000.00, the entire admission will be paid using the Stop-Loss Reimbursement Factor (SLRF) of 75%. Per Rule 134.401 (c)(6)(A)(v), the charges that may be deducted from the total bill are those for personal items (television, telephone), those not related to the compensable injury, or if an onsite audit is performed, those charges not documented as rendered during the admission may be deducted.

The carrier is allowed to audit the hospital bill on a per line basis. Per the information submitted by the carrier and the provider, an invoice was submitted with the per/unit cost of the implantables. In reading Rule 134.401 (c)(6), additional reimbursement **only** (emphasis added) applies if the bill does not reach the stop-loss threshold. The hospital is required to bill, "…usual and customary charges…" per Rule 134.401 (b)(2)(A). The carrier should audit the entire bill to see if the charges represent "usual and customary" amounts. This would include the implantables. Therefore, the carrier would audit the **implantables** and reduce them to "usual and customary" charges if they thought the bill for implantables was inflated. (It would not be appropriate to start out the audit by automatically reducing the cost of the implantables to cost + 10% to what is indicated in the Medical Fee Guideline since the rule states this method is used only for the per diem reimbursement methodology.) There was no documentation submitted by the carrier to

indicate that the reduction of the implantables was based on anything more than reducing them up front to cost + 10%. There is no documentation to indicate that the carrier attempted to determine the usual and customary charges billed by other facilities for implantables in the same geographical region as the Hospital. Even if the charge appears to be inflated based on the invoice or based on information from the Fee Guidelines, the carrier must determine what is usual and customary for those items in that region and billed by other facilities. If other facilities only bill cost + 10% for implantables, some evidence of that determination would be needed if the Hospital challenges the reimbursement amount. The carrier would also subtract any personal items or items not related to the compensable injury and then determine the final amount to see if the bill would be paid at the per diem methodology or the stop-loss methodology.

The carrier also brought up the issue of pre-authorization for the bone growth stimulator. Rule 134.600 (h)(3) "all external and implantable bone growth stimulators" require pre-authorization. According to Rule 134.600 (a) "The insurance carrier is liable for the reasonable and necessary medical costs relating to the health care treatments and services listed in subsection (h) of this section…(2) the treating doctor, his/her designated representative, or the injured employee has received pre-authorization from the carrier prior to the health care treatments or services…" The medical documentation submitted indicates that per-authorization was obtained, therefore the bone growth stimulator is pre-authorized along with the other health care treatments for the dates of service in dispute.

The hospital has billed its "usual and customary charge of $57,982.00 for the implantables. The carrier has not submitted evidence of what is usual and customary in that region for these items.

Therefore, the total reimbursement will be calculated in the following manner"

Total charges are $83,938.82.
Multiply the audited charges of $83,938.82 x 75%
$83,938.82 x .75= $62,954.12
The carrier paid $29,302.90
$62,954.12 - $29,302.90 = $33,651.22
Therefore, additional reimbursement is recommended in the amount of $33,651.22.

The above Findings and Decision are hereby issued this 10th day of July 2002.

Michael Bucklin, LVN
Medical Dispute Resolution Officer
Medical Review Division

VI. ORDER

Pursuant to Sections 402.042, 413.016, 413.031, and 413.019 the Medical Review Division hereby ORDERS the Respondent to remit $33,651.22 plus all accrued interest due at the time of payment to the Requestor within 20 days receipt of this order.

This Order is hereby issued this 10th day of July 2002.

Judy Bruce
Director Medical of Medical Review
Medical Review Division

JB/mb

This document is signed under the authority delegated to me by Richard Reynolds, Executive Director, pursuant to the Texas Workers' Compensation Act, Texas Labor Code Sections 402.041 - 402.042 and re-delegated by Virginia May, Deputy Executive Director.